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October 7, 1982 Letter Report 228.4

Honorable Walter M. Ingalls
Chairman, and Members of the
Joint Legislative Audit Committee
925 L Street, Suite 750
Sacramento, California 95814

Dear Mr. Chairman and Members:

In response to a request by the Joint Legislative Audit Committee, we compiled information regarding the State's expenditures for Medi-Cal fiscal intermediary services under the current contract with the Computer Sciences Corporation (CSC). We also estimated the loss of federal funds by the State because of delays in gaining full Federal Health Care Financing Administration (HCFA) certification of the Medicaid Management Information System (MMIS) within the CSC claims-processing system. We conducted this review under the authority vested in the Auditor General by Sections 10527 through 10528 of the Government Code.

We estimate that payments to the CSC will have totaled approximately $104.1 million for fixed cost and fixed rate payments, and $27.4 million for cost reimbursable payments for five years of service through the end of fiscal year 1982-83. We also estimate that an additional $12.9 million will have been spent for change orders. In addition, we estimate that approximately $3.4 million in federal funds were lost by the State due to delays in gaining HCFA's full certification of the MMIS within the CSC claims-processing system.

BACKGROUND

In November 1965, the Legislature created the California Medical Assistance Program, Medi-Cal. This program, authorized by Title XIX of the Social Security Act and Section 14000 et seq. of the Welfare and Institutions Code, pays for a variety of health care services to beneficiaries. Among these services are outpatient visits to physicians and other medical care providers, drugs, inpatient and outpatient hospital services, and long-term health care such as nursing home care. The State and the federal government jointly fund this program.

The Department of Health Services (department) has been designated as the single state agency responsible for administering the Medi-Cal program. The department does not, however, directly process and verify the claims of those providing services to Medi-Cal beneficiaries. These functions are performed by its fiscal intermediary, the Computer Sciences Corporation, which contracts with the State to process and verify the claims.

In August 1978, the department awarded the CSC a five and one-half year contract for processing Medi-Cal claims through February 29, 1984. The contract requires the CSC to design, develop, install, and operate the Medi-Cal claims processing system. The department delegated responsibility for managing and monitoring the CSC contract to its Fiscal Intermediary Management Division.

SCOPE AND METHODOLOGY

We limited our work to two specific areas. In the first area, we compiled payments made by the State for fiscal intermediary services from fiscal year 1978-79 through 1981-82. We obtained estimates for the 1982-83 fiscal year expenditures from the department. Budget projections are preliminary figures as of April 1982, with the exception of change orders, which are September 1982 estimates. We did not review source documents to substantiate invoiced costs. However, a judgmental sampling we conducted to test for mathematical errors revealed no discrepancies. Because the State operates on a cash basis, we recorded payments by year of payment rather than by year of service.

In the second area, we reviewed the federal financial participation that was lost because of delays in MMIS certification. However, we limited our review to an examination of invoices received from the CSC by the State for claims-processing services. From these invoices we estimated the number of claims-processing services that were eligible for federal financial participation. We then estimated the amount of federal financial participation available for these claims-processing services that might have been lost during any delay in the federal government's certification of the MMIS.

AUDIT RESULTS

In this section we present the results of our review. We first describe expenditures for fiscal intermediary services and then discuss lost federal financial participation.

Expenditures for Fiscal Intermediary Services

Table 1 on the next page summarizes the information on expenditures.

TABLE 1

PAYMENTS FOR FISCAL INTERMEDIARY SERVICES
TO COMPUTER SCIENCES CORPORATION:
STATE AND FEDERAL FUNDS FOR FISCAL YEARS 1978-79 THROUGH 1982-83
(UNAUDITED)

Nature of Expenditure	Expenditures				Projected Expenditures	Total
	1978-79	1979-80	1980-81	1981-82	1982-83	
Fixed Rate/Fixed Price Payments						
Design, development and installation	$5,671,067	$ 6,075,656	$ 529,079	$ 519,367	$ 74,304	$ 12,869,473
Operations	---	10,510,373	25,414,920	28,029,539	26,253,295	90,208,127
10 percent withholding	---	---	---	---	1,458,045	1,458,045
Liquidated damages	---	(194,500)	(177,000)	(58,500)	---	(430,000)
Subtotal	$5,671,067	$16,391,529	$25,766,999	$28,490,406	$27,785,644	$104,105,645
Cost Reimbursable Payments						
Cost reimbursements	---	$ 3,835,226	$ 5,296,133	$ 5,065,581	$ 5,214,679	$ 19,411,619
Sales tax	---	---	3,275,812	2,177,610	2,461,385	7,914,807
Hourly reimbursements	---	---	3,305	---	30,000	33,305
Subtotal	---	$ 3,835,226	$ 8,575,250	$ 7,243,191	$ 7,706,064	$ 27,359,731
Change orders						
# 2 Uniform Claim Form	---	---	$ 2,932,176	$ 80,884	---	$ 3,013,060
#12 Continuation of Uniform Claim Form	---	---	---	2,234,884	$ 258,524	2,493,408
#24 New claim form for physicians	---	---	---	46,794	2,998,041	3,044,835
#20 Medicare/Medi-Cal Crossover	---	---	---	186,997	541,255	728,252
Ancillary review	---	---	---	---	500,000	500,000
#676A System enhancements	---	---	---	---	1,769,520[a]	1,769,520
— AB 799 change orders	---	---	---	---	220,000[a]	220,000
— Other legislatively mandated change orders	---	---	---	---	497,475[a]	497,475
— Other change orders	---	---	---	17,166	608,302[a]	625,468
Subtotal			$ 2,932,176	$ 2,566,725	$ 7,393,117	$ 12,892,018
Total	$5,671,067	$20,226,755	$37,274,425	$38,300,322	$42,884,825	$144,357,394

[a] The figures for these items are preliminary estimates.

The following paragraphs discuss some of the expenditure items listed in Table 1.

Payments for design, development, and installation of the claims processing system are essentially complete. Turnover tasks (i.e., changing from one intermediary to another), which are priced at $131,349, will be paid at the end of the contract period.

The State reimburses the fiscal intermediary for the costs of items such as postage, printing, and State-used telecommunication lines and equipment. These items are subject to audit under the terms of the contract. The department has recently completed an audit of these items; the results of this audit will be released shortly.

In fiscal year 1980-81, the CSC began paying sales tax that was applied retroactively to the inception of the contract. In addition to the sales tax, the CSC also billed the State for additional corporate and divisional overhead as a percentage of this sales tax and added this amount to the sales tax charge. Through July 1982, this overhead charge, which the State has paid, has averaged 6.7 percent of the sales tax invoices, and it amounts to $366,909. Although overhead is an integral part of the CSC's service and is included in its pricing structure, we question basing this additional charge solely on sales tax.

Under the terms of the contract, 10 percent of the total fee for design, development, and installation is withheld until completion of these tasks. The 10 percent withholding for design and development ($648,295) was paid in July 1982. The 10 percent withholding for installation, approximately $806,750, is still outstanding.

Finally, the State has assessed and collected $430,000 in liquidated damages for nonperformance by the contractor. In addition, 24 assessments totaling $2.7 million were in dispute or litigation in March 1982 and remain unresolved as of September 1982.

Table 1 arrays costs by major change orders. A change order is a written request by the department's contracting officer to the contractor for changes to the contract. In addition to general information on change orders, we were asked to provide specific data on expenditures for ICD-9 diagnosis coding and Uniform Claim Form processing.* Expenditures for these two items span three different change orders, as shown in Table 2 on the next page.

* The International Classification of Diseases (ICD), Ninth Edition, is a system for cataloging diseases according to a universal numbering system.

TABLE 2

SELECTED CHANGE ORDER EXPENDITURES
BY TYPE OF SERVICE
FISCAL YEAR 1980-81 THROUGH FISCAL YEAR 1982-83[a]
(UNAUDITED)

Change Order Number	Description	Operations			
		ICD-9 Coding	Uniform Claim Form Processing	Design, Development, and Installation	Total
2	Uniform Claim Form	$1,727,283	$ 989,759	$296,018	$3,013,060
12	Continuation of Uniform Claim Form	1,856,418	636,990	---	2,493,408
24	New Claim Form for Physicians (40-1 Claim Form)[b]	2,998,041	---	46,794	3,044,835
	Total	$6,581,742	$1,626,749	$342,812	$8,551,303

[a] Includes projection for fiscal year 1982-83 by the Department of Health Services.

[b] Includes costs for phasing out Uniform Claim Form processing.

Change Orders 2, 12, and 24 are interrelated, involving claim forms and supplementary diagnosis coding. Under the original terms of the contract, providers were "required to submit claims on state approved claim forms." When the CSC developed the new claim form 40-1 for physicians, which the State approved, the medical community and other providers resisted the change, preferring to continue using the older Uniform Claim Form originally developed by the former fiscal intermediary. Consequently, Change Order 2 permitted continued use of the old Uniform Claim Form as well as the new 40-1 claim form. Change Order 2 also provided ICD-9 diagnosis coding for both forms when the provider supplied only a narrative description of the diagnosis.

Change Order 2 ran from June 1, 1980, through June 30, 1981. Change Order 12 extended the term and revised the rates for processing Uniform Claim Forms as well as for ICD-9 diagnosis coding. Finally, in accordance with 1981 budget act language, Change Order 24 provides for sole use of the optically scannable, new 40-1 claim form beginning in April 1, 1982. The change order also phases out Uniform Claim Form processing and provides for continued ICD-9 diagnosis coding for the 40-1 form with revised rates.

We were also asked to provide information on payments associated with change orders for label review and for the use of the federal claim form (HCFA 1500). There were no expenditures for either of these, however, because the State withdrew both change orders. The requirement for the CSC to review proof of eligibility labels on provider claims became unnecessary with the passage of AB 251 (Chapter 102, Statutes of 1981). This bill requires the provider to obtain identification that establishes the identity of the Medi-Cal beneficiary. The bill also precludes denying a provider's claim for the sole reason that a proof of eligibility label does not accompany the bill. Use of the HCFA 1500 claim form was cancelled when the department decided to require use of the 40-1 claim form (Change Order 24).

Lost Federal Financial Participation

To determine federal financial participation (FFP) lost due to delays in federal certification of the Medicaid Management Information System (MMIS), we reviewed fiscal intermediary invoices for the following five claim types: pharmacy, long-term care, inpatient, outpatient, and medical. While noncertified claim types receive only 50 percent FFP, certified claim types qualify for 75 percent FFP. We noted that none of the five claim types was completely certified when these claim types were available for certification, resulting in a loss of 25 percent of FFP. The nonphysician segment of the medical claim type, which represents 56.5 percent of all medical claims processed, was certified when it was available for certification. The physician claim portion of the medical claim type, representing the remaining 43.5 percent of the claims processed, is still not certified because the department did not require individual physicians in group practices to submit individual provider numbers on claim forms. Thus, it could not be determined if an individual physician was eligible to provide Medi-Cal services. Officials of the Health Care Financing Administration anticipate that the physician portion of the medical claim type will be certified with an effective date of January 1, 1982.

We estimate that the State did not receive approximately $3.4 million in federal financial participation because there were delays in MMIS certification. Table 3 depicts the estimated lost FFP by claim type.

TABLE 3

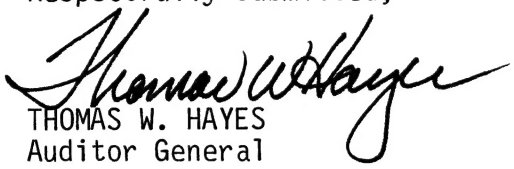
ESTIMATED FEDERAL FINANCIAL PARTICIPATION (FFP)
LOST DUE TO DELAYS IN MMIS CERTIFICATION

Claim Type	Date Segment Available for Certification	Effective Date of Certification	Time Elapsed	Estimated Dollars Available for FFP Billed During Elapsed Time	Estimated FFP Lost (Dollars x 25%)
Pharmacy	July 1, 1979	April 1, 1980	9 months	$4,592,018.75	$1,148,004.68
Long-Term Care	October 1, 1979	April 1, 1980	6 months	$ 65,698.83	16,424.70
Inpatient	January 1, 1980	April 1, 1980	3 months	$ 294,756.53	73,689.13
Outpatient	January 1, 1980	April 1, 1980	3 months	$1,015,419.19	253,854.79
Medical-Physicians	July 1, 1980	January 1, 1982[a]	18 months	$7,551,216.73	1,887,804.19
Total					$3,379,777.49

[a] Both state and federal officials anticipate that the physician portion of the medical claim type will be certified retroactive to January 1, 1982.

Although we did not ask the Department of Health Services to respond formally to this report, we did meet with the Deputy Director of the department's Fiscal Intermediary Management Division to discuss the report's contents. This department official took no major exceptions to this report.

Respectfully submitted,



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